

THE NEW YORK PSYCHOANALYTIC INSTITUTE
247 East 82 Street, New York, NY 10028
(212) 879-6900

Child/Adolescent Application for Evaluation for
Psychoanalysis, Psychotherapy, and/or Psychological Testing

THIS APPLICATION WILL BE KEPT CONFIDENTIAL

NAME:

TELEPHONE: Res:

Bus:

HOME ADDRESS:

SEX:

AGE, WITH DATE OF BIRTH:

STUDENT AT:

GRADE:

How did you find out about our Treatment Center?:

Name and Address of responsible relative:

PRINCIPAL COMPLAINT OR COMPLAINTS (List in order of importance, using single words, phrases, or short sentences.):

Referral for (check a. or b. or both):

a) Evaluation for possible treatment ___

b) Psychological testing ___

FAMILY BACKGROUND (Give ages of grandparents, parents, brothers, sisters, brief mention of important illnesses -- mental or physical -- occupations, marital status. If any are deceased, give age, cause of death, and year of death.):

FINANCIAL (Include family's salaries, insurance, other sources of family income, and unusual expenses.):

EDUCATION (List schools/nurseries attended, with dates; degrees, diplomas, or highest grade completed.):

GEOGRAPHIC (Include place of birth and outline of principal changes of place thereafter.):

MEDICAL (List, with dates, all important illnesses or injuries -- medical or surgical. Give names and addresses of doctors or hospitals by whom treatment was conducted.):

PSYCHIATRIC (List, with dates, names and addresses, and fees paid, all consultations and previous psychotherapy or psychoanalysis, including consultations with psychologists, social workers, or guidance counselors. Also list applications in process with other psychiatric clinics. Please also list previous applications to our Treatment Center.):

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Treatment Center

INFORMED CONSENT

I understand that the Treatment Center of the New York Psychoanalytic Institute will write to the physicians, therapists, hospitals, and social agencies previously mentioned. I authorize the Treatment Center to make such inquiries. I authorize the professionals and agencies previously mentioned to answer any inquiries that the Treatment Center may make in connection with this application. In addition, I authorize any examiner for the Treatment Center to make a full report to the Treatment Center of his or her findings, diagnosis and recommendations. In order to facilitate appropriate referrals, I authorize the Treatment Center to fully communicate with and to provide all necessary information to other physicians, therapists, hospitals, school officials, teachers, or social agencies.

Signed: _____

Dated: _____

If applicant is under 18 years of age, please have parent or guardian sign.

I understand that patients accepted for this program will be treated or tested by therapists who are in training and who are supervised in their work by experienced analysts on the faculty of The New York Psychoanalytic Institute and Society.

Signed: _____

Dated: _____

If applicant is under 18 years of age, please have parent or guardian sign.

All applicants will be considered without regard to race, color, religion, national origin, age, sex, or marital status. The Treatment Center has a policy of nondiscrimination because of disability, for persons otherwise qualified, in accordance with New York and Federal law.

3/04